SERVICE LIMITS PRIOR AUTHORIZATION REQUEST

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 481 (Rev. 11-2003)

Clear Fields

Send to: Medical Services Division
ND Department of Human Services
600 E Boulevard Ave, Dept. 325
Bismarck, ND 58505
Fax: (701) 328-1544

PROVIDER INFORMATION

Provider Name	Provider Number	Telephone Number	Fax Number

Address	City	State	Zip

RECIPIENT INFORMATION

Last Name, First Name, Middle Initial	Medicaid ID Number	Sex	Date of Birth
		☐ Male ☐ Female	

Check Area(s) of Request:

- ☐ Chiropractic Manipulation Visit
- ☐ Physical Therapy Visits/Evaluation
- ☐ Psycho Therapy Visits (PHD, MSW, etc.)
- ☐ Occupational Therapy Visits/Evaluation
- ☐ Speech Therapy Visits/Evaluation
- ☐ Psychology Testing

EXPLAIN NATURE OF REQUEST (RETRO OR FUTURE) INCLUDING MEDICAL NECESSITY:

*** PLEASE ATTACH CARE PLAN IF APPLICABLE**

Additional Visits/Therapies Requested:

Date of Last Service Limit Request	Signature of Requesting Provider	Today's Date

REMARKS: **(STATE USE ONLY)** ☐ Approve ☐ Deny	Number of Visits Approved	Start Date	End Date

Comments

Signature